Patterns and Trends in Drug Abuse in St. Louis, Missouri: 2013

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ABSTRACT

Key findings in the St. Louis area included persistently high levels of heroin with renewed attention on prescription opiates and methamphetamine. Heroin availability and its widespread presence in the St. Louis rural and suburban areas continued to be a concern in 2013. Two types of heroin were available in the St. Louis Metropolitan Statistical Area—Mexican black tar and Mexican off-white powder. The proportion of St. Louis area primary treatment admissions for heroin exceeded all other drugs, including alcohol. The number of deaths involving heroin remained high, and such deaths were identified in rural medical examiner (ME) data as well as in metropolitan area data. All sources (from school surveys and emergency department visits to law enforcement data) have reported access to heroin to be consistent, with the drug at high purity. Other opiates (prescription opiates, fentanyl, and methadone) remain in both treatment and ME indicators, and access is not monitored. Methamphetamine indicators remained low with an increase in treatment admissions; access in rural areas was reported and noted in death data and statewide treatment data. The number of methamphetamine clandestine laboratories remained high. Social networks continued to produce small amounts of the drug locally. Methamphetamine from Mexico and the Southwest supplied most of the methamphetamine in the city and county of St. Louis and in the surrounding five Missouri counties. Crack cocaine, formerly the major stimulant problem in the area, stabilized at low levels in all indicators for 2013 but remained available, particularly in the city. Marijuana indicators remained stable in 2013, with 31.1 percent of treatment admissions in the 12–17 age group. Reports of "club drug" abuse continued to be sparse, primarily through anecdotal reports of MDMA (3,4-methylenedioxymethamphetamine) use and a few PCP (phencyclidine) and ketamine ME cases. "Bath salts" (synthetic cathinones) have decreased dramatically in poison control center reports; their use decreased with control legislation. In the St. Louis area, about 5 percent of human immunodeficiency virus (HIV) cases had a primary risk factor of injection drug use, with most new cases identified among men who have sex with men (78.6 percent) and women of color who contracted it through heterosexual contact (17.2 percent). While the St. Louis region has the highest number of individuals living with HIV/AIDS (acquired immunodeficiency syndrome), there are more than 6,000 men, women, and children who have died from HIV/AIDS in the State since 1982. Cases of sexually transmitted diseases remain high despite years of education and behavioral interventions from the health departments, academic institutions, and health care workers.

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INTRODUCTION

Area Description

The St. Louis Metropolitan Statistical Area (MSA) includes approximately 2.2 million people. Most of the population lives in the city of St. Louis and St. Louis County; others live in the surrounding rural Missouri counties of Franklin, Jefferson, Lincoln, St. Charles, and Warren. Redefinition of the MSA has resulted in an area that includes a total of eight Missouri counties and eight Illinois counties, reflecting the population sprawl since the last U.S. Census. St. Louis City's population continued to decrease to less than 350,000, many of whom are indigent and minorities. However, revitalization, with an increase in young professionals, has led to conflicts with marginalized populations in the city. While murders rose slightly in St Louis City, overall violent crime was down 5.4 percent in 2013. St. Louis County, which surrounds St. Louis City, has more than 1 million residents and is a mix of established affluent neighborhoods and middle- and lower-class housing areas on the north and south sides. The most rapidly expanding population areas are in St. Charles and Jefferson Counties in Missouri and in St. Clair and Madison Counties in southern Illinois, which have a mixture of small towns and farming areas. The population in these rural counties totals more than 800,000. Living conditions and cultural differences between the urban and rural areas have resulted in contrasting drug use patterns.

Much of the information included in this report is specific to St. Louis City and County and the surrounding rural counties, with caveats that apply to the total MSA. Anecdotal information and some medical examiner (ME) data and treatment data are provided for rural areas surrounding St. Louis.

Policy Issues

Even with legislation for precursor drugs, such as pseudoephedrine, methamphetamine use and local production continued for several reasons. The policy cannot address the vast majority of methamphetamine imported from Mexico and the social networks that produce smaller amounts of methamphetamine. Attention is now focused on heroin, prescription opiates, and marijuana. The city has passed a decriminalization law making possession of small amounts of marijuana a "fine," which met with resistance from abstinence groups, and discussions of marijuana legalization have polarized many groups.

Limited treatment availability continues for drug abusers and mental illness. Consequently, treatment numbers may underestimate the scope of the substance abuse problem when used as an indicator. Medicaid offers treatment services to women and children on a limited outpatient basis. The future funding of mental health and substance abuse treatment is the subject of potential cutbacks as the State attempts to balance its budget.

Data Sources

The data sources used in this report are listed below:

- **Drug treatment data** were derived from the Treatment Episode Data Set (TEDS) database for 2013. Private treatment programs in St. Louis County provided anecdotal information.

- **Drug price and purity information** was provided by the Drug Enforcement Administration (DEA), Domestic Monitor Program (DMP), through 2013.
- **Drug-related mortality data** were provided by the St. Louis City and County ME Office for 2013.
- **Intelligence data** were provided by the Missouri State Highway Patrol and the DEA.
- **Data on drug reports among drug items seized and analyzed in forensic laboratories** were provided by the DEA, National Forensic Laboratory Information System (NFLIS), for 2013. NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data are a combined count including primary, secondary, and tertiary reports for each drug item.
- **Client ethnographic information** was obtained from user/key informant interviews.
- **Human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and sexually transmitted disease (STD) data** were derived from the St. Louis Metropolitan Health Department and the Missouri Department of Health and Senior Services for 2012.
- **Methamphetamine clandestine incident information** for 2013 came from the Missouri State Highway Patrol.
- **Anecdotal reports** were provided by local agencies that provide crisis intervention services and the St. Louis County Toxicology Laboratory and Poison Control project.

DRUG ABUSE PATTERNS AND TRENDS

Regionally, indicators for the major substances of abuse remained stable in 2013. Cocaine availability, proportions of treatment admissions, and numbers of deaths decreased, while heroin availability and treatment admissions remained high and stable in all indicators. Anecdotal information from the DEA and local agencies indicated that heroin use, purity, and availability have increased regionally, including rural and suburban areas surrounding St. Louis. Heroin indicators surpassed cocaine and marijuana indicators in treatment admissions data. Death data for St. Louis City and County showed slight increases in heroin and other opiates over the past year. Two types of heroin continued to be available in the area. Heroin remained pure and was less expensive than that which was available in previous years. St. Louis is a destination market and is subject to all the changes that occur in the supply chain. Heroin is also cheaper and easier to obtain for addicted users.

Fentanyl, methadone, oxycodone, and hydrocodone continued to be reported in ME and treatment admissions data. Prescription narcotic analgesics were reported to be available in the more rural areas of the MSA.

Methamphetamine indicators were mixed in 2013, but methamphetamine indicators remained high as a drug of abuse in cities other than St. Louis and in the rural areas of Missouri. The influence of the distribution networks and combining of distribution networks for cocaine and heroin has led to increased availability throughout the region. Clandestine laboratories decreased from 2012, but they were still at high numbers; 33 percent of these laboratories were in the St Louis reporting area. Deaths overall were the same in 2013 and 2012.

Marijuana continued to be a very popular drug of abuse among younger adults. Gangs continued to be involved in the drug trade and related violence, with Latino, African-American, and Asian youth and young adults involved in these groups. Interdiction programs are active in the city and along major interstate highways.

The use of "bath salts" (synthetic cathinones), which has been widely publicized, has decreased dramatically. Prescription narcotics, hypothesized to contribute to younger users' introduction into the heroin culture, and diversion of prescription drugs have changed the stereotype of the heroin user and the face of heroin use in the Midwest.

Drug education and prevention activities have continued at the community level, particularly about heroin and its effects. The National Council on Alcoholism and Drug Abuse and other local education programs target prevention of drug use in the area. Faith-based initiatives are also involved in prevention. These groups are particularly active in the counties surrounding St. Louis.

Alcohol and other categories remained more stable. While not reported separately, alcohol abuse and underage use of alcohol continued to be community concerns. Many of the polydrug deaths and personal violence incidents have included alcohol use. In St. Louis, in 2013, 31.6 percent of treatment admissions were for alcohol alone.

Crack/Cocaine

The ME data report for 2013 for the St. Louis area showed that deaths in which cocaine was involved were stable compared with 2012. Such deaths declined from 167 in 2007 to 51 in 2013 (exhibit 1). Some deaths in older cocaine users were associated with cardiovascular catastrophic incidents, such as aneurysm or intracranial hemorrhage.

Cocaine was the fourth most common primary drug of abuse among all treatment admissions in 2013, following heroin, alcohol, and marijuana. This represents a change for the region over the past 7 years, as the numbers of primary cocaine admissions have decreased, while admission numbers for drugs such as heroin have increased. Cocaine represented 7.2 percent of admissions (5.7 percent for crack), compared with 16.9 percent for marijuana and 34.3 percent for heroin admissions (exhibit 1). In 2013, males constituted 61.0 percent and females constituted 39.0 percent of cocaine admissions. Of these cocaine treatment clients, 83.5 percent were older than 35. Marijuana, heroin, and alcohol were the most frequently cited secondary and tertiary drugs of abuse among primary cocaine admissions in 2013.

While the DEA's emphasis in the St. Louis area has shifted from cocaine to methamphetamine and heroin, reports from law enforcement sources, the DEA, and street informants indicated increasing quality and availability for cocaine, with continuing higher prices in urban St. Louis (exhibit 2). The price per rock was reported to be climbing. Anecdotal information indicated that all cocaine in St. Louis is initially in powder form and is converted to crack for distribution. In the past, cocaine was readily available on the street corner in rocks or grams, but this picture was changing. No new information was available on cocaine pricing in Kansas City and in smaller cities outside St. Louis.

NFLIS data indicated that 1,772 (10.7 percent) drug reports among drug items seized and identified in NFLIS laboratories in 2013 for the St. Louis MSA were identified as containing cocaine. This

placed cocaine as the third most frequently identified substance in the NFLIS system during 2013, a lower ranking than in previous reporting periods.

Most primary cocaine treatment clients (85.7 percent) reported smoking crack cocaine in 2013. A decrease in the use of combined cocaine and heroin ("speedball") by injection drug users (IDUs) has been noted, but that has been replaced with many other combinations (such as cocaine with methamphetamine or other opiates). Polydrug use was also evident in the treatment data. The reported use of marijuana, heroin, and alcohol in addition to cocaine suggested this trend will likely continue.

Heroin

Heroin was stable at high levels in the St. Louis area in all indicators in 2013 (exhibit 1). The ME data report for 2013 showed an increase in heroin-related deaths in an area covering St. Louis City and St. Louis County and the rural counties of Franklin, Jefferson, and St. Charles. The ME identified 236 heroin-related deaths, an increase from 206 in 2012 but down from 310 in 2011. Of these deaths, 26.3 percent were younger than 30; 70 percent were Caucasian. There were 95 deaths in the city and 98 heroin-related deaths in St Louis County. Of the total heroin deaths, 43 were reported from Jefferson, Franklin, and St. Charles Counties. In 2009, heroin was identified in 180 deaths in St. Louis City and County. In 2008, heroin was present in 137 deaths, while in 2007 and 2006, heroin was present in 65 and 47 deaths, respectively, in St. Louis. Even with the decreased availability of cocaine, a small percentage of these deaths represented use of heroin and cocaine together, many times also mixed with alcohol.

Heroin availability and purity began to climb in late 2008. Prior to that increase in availability and purity, heroin was found among small pockets of IDUs. With this increase in deaths and spreading use, many communities became alarmed. Grassroots public awareness efforts may be responsible for an effect with the young potential new user. Access to heroin is reported in St. Louis County schools, a phenomena not seen until 2011.

Heroin treatment admissions in 2013 represented 34.3 percent of all admissions; this proportion exceeded those for alcohol admissions. An upward trend began in 2006, when heroin admissions increased by 15.5 percent from 2006 to 2007; such admissions grew by another 49.0 percent in 2008. In 2009, treatment admissions continued to climb among clients younger than 35. In 2013, 61.4 percent of heroin treatment admissions were younger than 35 (although this was slightly lower than in the previous 3 years), and 20.4 percent were younger than 25 (exhibit 1). Admissions to some available treatment depended on ability to pay. Some heroin abusers in need of treatment utilized private pay methadone programs. Buprenorphine is a treatment option at private centers, but it is expensive. Some younger users were reporting initial addiction to prescription pain pills prior to starting to use heroin. Of the methods of administration, 66.7 percent of heroin treatment clients reported injection use, a slight increase over 2012 (exhibit 1). This trending back to injection has not coincided with lower purity, but it is linked to reported widespread experimentation in the use of the drug in social circles that previously would not use heroin throughout the region. The stability in deaths, increase in treatment admissions, and consistently high purity of heroin presents a stable, if not saturated, current picture of heroin. Among heroin treatment admissions, males accounted for 60.7 percent, while females represented 39.3 percent. Cocaine and marijuana were the most frequently cited secondary and tertiary drugs of abuse for heroin clients.

A steady supply of what is presumed to be Mexican heroin remained available; both the DEA and DMP made heroin buys in the region. Mexican black tar heroin remains pure. Purities of 20–55 percent pure have been reported for the off-white or tan powder, a slightly bleached version of this powder. Additional heroin in St. Louis has not been identified as to its origin (signature) and was assumed to be Mexican. The consistently higher purity in St. Louis has allowed for expansion into a larger market with inexperienced users. Most heroin was purchased in a capsule (one-tenth-gram packages of heroin) for $10–$20 or as one-half-gram baggies that sold for $100 each (exhibit 2). Quetiapine (Seroquel®) has been identified as a cutting agent in many samples, as well as the standard cutting agents typically used (such as diphenhydramine).

The city of St. Louis is an end-user market and is dependent on transportation of heroin from points of entry into the Midwest. The wholesale price remained at $100−$400 per gram, depending on heroin type. On street corners, heroin sold for $150 per gram, according to anecdotal reports. In St. Louis and other smaller urban areas, small distribution networks sold heroin. Kansas City's heroin supply differed from that of St. Louis, due to trafficking source differences. Mexican black tar heroin was primarily available there. The lighter color, more potent heroin did not to appear to be available in the Kansas City metropolitan area. Of the reports among drug items seized and identified by NFLIS laboratories in 2013, 16.3 percent were identified as containing heroin.

Other Opiates/Narcotics

Other opiates represented 3.6 percent of all treatment admissions in 2013. These admissions for abuse of other opiates seem to represent a slight increase in treatment admissions, but this may be underrepresented by the lack of treatment availability. Prescription opiates are believed to be linked to the introduction of younger users to the effects of opiates, possibly assisting in the fueling of heroin use by a wide range of users. No pharmacy database exists in Missouri to monitor these prescriptions. These abusers were diverse: young users recreationally getting high, chronic pain medication abusers, and, more recently, discussions of polydrug geriatric abusers.

Methadone abuse continued to be noted. The two most frequently identified opiates, following heroin, among reports detected in drug items seized and analyzed by NFLIS laboratories in the St. Louis MSA were hydrocodone and oxycodone. NFLIS data for 2013 indicated that the proportion of hydrocodone reports from drug items seized and identified by forensic laboratories ranked sixth among all reports (3.1 percent), while oxycodone reports ranked seventh and represented 2.8 percent of the total reports identified among drug items. Of the NFLIS reports from drug items seized, oxycodone and hydrocodone represented 5.9 percent of these reports.

OxyContin® (a long-lasting, time-release version of oxycodone) abuse remained a concern for treatment providers and law enforcement officials, and it was seen in emergency departments by patients requesting refills. Many emergency departments have adopted refill policies for narcotics to prevent abuse. Abuse of oxycodone remained a concern in medical settings, where the drug is preferentially sought. The use of hydromorphone remained common among a small population of White chronic addicts, based on anecdotal information (exhibit 2). New extended release narcotics will complicate the prescription drug abuse picture.

Fentanyl continued to appear in ME data, with 27 deaths in St. Louis City and County and the 3 targeted rural counties (St. Charles, Jefferson, and St Frances) in 2013. Methadone overdoses were

reported in 2013 in 24 cases. The use of illicit methadone versus prescription methadone has been difficult to quantify.

Benzodiazepines/Depressants

The remaining few private treatment programs in the State often provided treatment for benzodiazepine admissions, antidepressant clients, and primary alcohol abusers. Social setting detoxification and day hospitals have become the treatment of choice for individuals who abuse these substances.

Benzodiazepines such as alprazolam and lorazepam are often abused after being initially prescribed for the treatment of anxiety. A life-threatening situation occurs when these drugs are combined with alcohol and heroin or other opiates. Benzodiazepines were identified in 4 heroin, 12 alcohol, and 2 cocaine ME cases in 2013.

Stimulants/Methamphetamine

Methamphetamine ("crystal" or "speed"), along with alcohol, remained a primary drug of abuse in both the outlying rural areas and statewide (most of Missouri, outside of St. Louis and Kansas City, is rural). Methamphetamine continued to be identified as a problem in rural communities. The drug appeared regularly in treatment data in rural areas, and methamphetamine has been identified as a problem in all parts of the State. Primary treatment admissions for methamphetamine in 2013 in St. Louis represented 4.3 percent of total admissions (*n*=565), compared with 3.4 percent (*n*=437) in 2012 and 2.5 percent in 2011 (*n*=320) (exhibit 1). While the treatment admission numbers have increased gradually over the past few years in St. Louis, methamphetamine is available and used at higher levels in other parts of the State. Females outnumbered males entering treatment (females=51.2 percent, or *n*=289 admissions) in 2013 (exhibit 1). Marijuana and alcohol and some heroin were the most frequently cited secondary and tertiary drugs of abuse among these clients. Clients entering treatment were typically self-referred. The number of reported methamphetamine deaths remained low, with 27 deaths reported in the region by the ME in both 2012 and 2013. Some African-American use of methamphetamine was reflected in these reported deaths. Methamphetamine use increased by 29.3 percent in the St. Louis region in 2013, compared with increases of 28.7 percent in northwest Missouri and 3 percent in southeast Missouri. Treatment admissions were much higher in other parts of the State in 2013: there were 994 methamphetamine admissions in central Missouri, 2,248 admissions in the northwestern region, 1,173 admissions in the southeastern region, and 1,936 admissions in the southwestern region.

Statewide, 1,496 clandestine laboratories were identified in Missouri in 2013, with many of these laboratories located in the rural counties surrounding St. Louis. Of these laboratories, 502 clandestine ones were located in the St. Louis MSA.

Hispanic traffickers were the predominant methamphetamine distributors in St. Louis. Shipments from "super laboratories" in the Southwest were trucked in on the interstate highway system. This network contrasts with the local "mom and pop" laboratories that fueled much of the methamphetamine debate in the State over the past 10 years. The purity of the methamphetamine obtained through this source has improved in recent years. Crystallized methamphetamine was available in Kansas City and outlying areas of the State, with some availability in St. Louis.

Mexican ice sold for $100 per gram in St. Louis in 2013 and for as little as $80–$100 per gram in the Kansas City area (exhibit 2). NFLIS data for 2013 showed methamphetamine was present among 9.2 percent of drug reports among drug items seized and analyzed, ranking fourth.

Pseudoephedrine reports represented 1.2 percent of total reports among seized drug items analyzed during this period. Because methamphetamine is so inexpensive and appeals to a wide audience, it is likely that its use will continue, particularly in rural Missouri.

Marijuana

Marijuana admissions in 2013 (*n*=2,192) accounted for 16.9 percent of all admissions in the St. Louis region; this may be related to heroin prevalence and treatment slot availability (exhibit 1). Marijuana, viewed by young adults as acceptable to use, was often combined with alcohol. Some prevention organizations reported resurgence in marijuana popularity, and a recent decrease in penalties in St. Louis City brought opposition from prevention organizations. The 25-and-younger age group accounted for 56.1 percent of primary marijuana treatment admissions in 2013. A large increase in the 12–17 age group entering treatment was evident starting in 2011, and this group represented 31.1 percent of treatment admissions in 2013. Increased THC (tetrahydrocannabinol) content of marijuana should not be ignored as a component of voluntary admissions.

Marijuana was available from Mexico or domestic indoor growing operations; marijuana from Mexico was classed as lower grade and less expensive ($200–$400 per ounce) (exhibit 2). Indoor production makes it possible to produce marijuana throughout the year; marijuana grown indoors was a higher grade and more expensive ($400–$600 per ounce). The going rate for an “eighth” (about 3.5 grams) was $60. Marijuana prices in Illinois were similar. The Highway Patrol Pipeline Program monitors the transportation of all types of drugs on interstate highways. Much of the marijuana grown in Missouri is shipped out of the State. Marijuana remains the most frequently identified substance among reports from drug items (27.1 percent) seized and analyzed by the NFLIS system in the St. Louis area in 2013.

Hallucinogens

PCP (phencyclidine) has been available in limited quantities in the inner city and has generally been used as a dip on marijuana joints. While PCP was not seen in quantity, it remained in most indicator data and police exhibits and as a secondary drug in two cases in the 2013 ME data. Most of the users of this drug in the inner city were African-American; it remained an indigenous drug of choice.

“Club Drugs”

Indicators for MDMA (3,4-methylenedioxymethamphetamine) and other “club drugs” indicated levels were low. There were occasional references to smoking “Molly” from marijuana users. The number of reports identified as MDMA among drug items seized and analyzed by NFLIS laboratories (*n*=72) may support anecdotal reports (obtained through special epidemiology projects on general substance use) of use of this substance in the St. Louis area. Ketamine was noted in one case in the 2013 ME data.

Synthetic Cathinones and Synthetic Cannabinoids

Synthetic cathinones, marketed as "bath salts," have been legislated to stop sales in a number of communities, and good response to aggressive enforcement has closed "head shops" attempting to sell and repackage these substances. No reports were noted in the 2013 ME data. According to poison control center reports, in 2013, there were 27 synthetic cathinone calls and 96 THC homolog calls, compared with 149 "K2" synthetic cannabinoid exposure calls in 2012. This is in contrast with 286 exposure calls in 2011.

INFECTIOUS DISEASES RELATED TO DRUG ABUSE HIV/AIDS

New seropositive HIV and AIDS cases among IDUs remained low in the St. Louis HIV region, which includes St. Louis City and County and Franklin, Jefferson, St. Charles, Lincoln, and Warren Counties (exhibit 3). In 2011, as in preceding years, the predominant number of new HIV cases occurred among men who have sex with men (MSM) (78.6 percent), followed by cases resulting from heterosexual contact (13.8 percent). The largest increases were found among young African-American females, who were infected through heterosexual or bisexual contact, and young homosexual African-American males. Of the 226 new HIV and AIDS cases in the St. Louis region, African-American females and African-American males accounted for more than one-half of new cases. Increased specialized minority prevention and testing efforts have been initiated.

Of the total cases of persons living with HIV/AIDS (*N*=5,482) through 2012, the same primary exposure categories are reflected: MSM, representing approximately 79 percent, and heterosexual contact, accounting for approximately 17 percent. Among new cases from 2012, injection drug use was noted in 5.4 percent of HIV cases and in no new IDU AIDS cases (exhibit 3). Of the more than 6,000 deaths from HIV/AIDS statewide since 1982, the major risk factor has been MSM, with a disproportionate number of White men represented.

STDs and Hepatitis C

Increased efforts in more tertiary prevention and active education campaigns in the highest risk populations have been used in an attempt to change STD rates. Rates of gonorrhea have remained steady, as have chlamydia rates. The St. Louis Metropolitan Health Department reported 9,339 chlamydia cases and 3,485 gonorrhea cases during 2013. In addition, 270 cases of syphilis were diagnosed in 2013 (exhibit 5). The leveling off in some STDs is hypothesized to be due to better antibiotics, single-dose treatments, and better screening in the community. Syphilis/gonorrhea rates were high in neighborhoods known to have high levels of drug abuse and in the MSM cohorts, underscoring the concept of assortative mixing in cohorts. Exhibit 4 includes historic HIV and hepatitis C data for the immediate St. Louis City area.

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Exhibit 1. Indicators From Mortality and Treatment Admissions Data for Cocaine, Heroin, Marijuana, and Methamphetamine, St. Louis: 1996–2013 for Mortality Data and 2006–2013 for Treatment Data

Indicator	Cocaine	Heroin	Marijuana	Methamphetamine
Number of Deaths[1] by Year				
1996	93	51	NA[2]	9
1997	43	67	NA	11
1998	47	56	NA	9
1999	51	44	NA	4
2000	66	47	NA	9
2001	75	20	NA	3
2002	76	50	NA	—
2003	78	61	NA	—
2004	38	64	NA	—
2005	106	31	NA	—
2006[3]	42	47	NA	—
2007[3]	167	65	NA	4
2008[3]	95	137	NA	7
2009	70	180	NA	1
2010	44	129	NA	3
2011[1]	91	310	NA	21
2012[1]	49	206	NA	27
2013[1]	51	236	NA	27
Treatment Admissions Data				
Percent of all Admissions (2013)	7.2	34.3	16.9	4.3
Percent of all Admissions (2012)	8.2	34.2	16.9	3.4
Percent of all Admissions (2011)	10.8	31.4	19.1	2.5
Percent of all Admissions (2010)	10.6	26.5	21.5	2.8
Percent of all Admissions (2009)	12.0	22.5	21.3	2.5
Percent of All Admissions (2008)	17.8	18.8	23.7	2.7
Percent of All Admissions (2007)	22.8	15.5	20.3	2.5
Percent of All Admissions (2006)	25.6	13.2	22.7	3.0
Gender (%) (2013)				
Male	61.0	60.7	71.0	48.8
Female	39.0	39.3	29.0	51.2
Age (%) (2013)				
12–17	<0.1	<1.0	31.1	2.3
18–25	3.1	20.0	25.0	20.0
26–34	13.3	41.0	23.1	39.8
35 and Older	83.5	38.6	20.8	37.9
Route of Administration (%) (2013)				
Smoking	85.7	<1.0	99.4	43.0
Intranasal	10.3	32.1	0.1	6.0
Injecting	2.1	66.7	0.0	49.2
Oral/Other	1.9	0.7	0.5	1.8

[1]Includes rural deaths.
[2]NA=Not applicable
[3]St. Louis City/County Medical Examiner's Office Data manual reports.
SOURCES: St. Louis City/County Medical Examiner's Office; TEDS database

Exhibit 2. Other Combined Indicators for Cocaine, Heroin, Marijuana, and Methamphetamine, St. Louis: 2002–2013

Indicator	Cocaine	Heroin	Marijuana	Methamphetamine And Other Drugs
Multisubstance Combinations	Older users combine with heroin, alcohol Mostly urban users	Very Available Mix with cocaine, amphetamines, opiates, alcohol	Alcohol Some discussion of smoking Molly (MDMA)	Marijuana commonly used in combination, Alcohol use
Market Data (2008–2012)	Powder $200–$400/g, crack $20–$40/rock Purity has improved in last year	$100/1/2 g baggie; $20 per gel capsule; depending if MBP[1] or SA[1] Brown or off-white origins identified as Mexican, South American, and unknown signature type $200/g, 20–40 percent pure, street reports higher purity available	Low grade: $200–$400/ oz; High grade (indoor grow, includes various types): $1,400/oz	Methamphetamine $100/g, Mexican (80–90 percent pure) and local (80 percent pure) Prescription opiates; no prescription monitoring data base; hydromorphone $80–$100/4-mg pill; OxyContin® $20–$40, Tramadol®, Percocet®, Vicodin®, Fentanyl
Qualitative Data[2]	Increasing availability; increased urban choice	Younger users, 22% younger than 25, consistent availability and purity	Readily available, younger users in treatment (58%)	Rural/suburban users of amphetamine—increase in deaths, larger rural treatment admissions
Other Data of Note	Older users have increased risk of cardiovascular incidents	MBP and Mexican white—increased injection use, broad user base, users able to smoke/ snort	Paraphernalia with the adolescent/ young adult use of e-cigarettes	Methamphetamine local laboratories slightly down; laboratory seizures decreased in 2013: mom/pop laboratories; producers in super laboratories controlled by Hispanic groups

[1]MBP=Mexican brown and white powder; SA=South American.
[2]Obtained from user/key informant interviews.
Note: g=gram; oz=ounce; mg=milligram.
SOURCES: DEA; NDIC; Client Ethnographic Information

Exhibit 3. Number and Percentage of Persons with HIV (New HIV/AIDS and Existing Cases), by Exposure Category, St. Louis Metropolitan Area: Through 2012

Exposure Category	New Cases HIV 2012 Number (Percentage)	Living with HIV Through 2012 Number (Percentage)	New Cases AIDS 2012 Number (Percentage)	Living with AIDS Through 2012 Number (Percentage)
MSM	176 (78.6)	1,945 (73.3)	44 (73.3)	1,971 (70.7)
IDU/MSM	5 (2.2)	65 (2.5)	0	113 (4.1)
IDU	12 (5.4)	99 (3.7)	0	159 (5.7)
Heterosexual	31 (13.8)	538 (20.3)	16 (26.7)	527 (18.9)
Hemophilia/ Coagulation Disorder	0	4 (0.2)	0	18 (0.6)
Blood Transfusion	0	1 (0)	1 (0)	1 (0)
Pediatric Population	2 (<1)	27 (<1)	0	14 (<1)
Total	**226**	**2,679**	**60**	**2,803**

Note: MSM=men who have sex with men; IDU=injection drug user.
SOURCES: St. Louis City Health Department; Missouri Department of Health

Exhibit 4. Number of New HIV and Hepatitis C Cases, St. Louis: 2002−2012

Year	Numbers of	
	New HIV Cases	New Hepatitis C Cases
2002	178	227
2003	197	488
2004	122	540
2005	171	512
2006	227	305
2007	198	1,217
2008	212	1,415
2009	259	1,252[1]
2010	300	1,489[1]
2011	234	1,805[1]
2012	226	1,629

[1]St. Louis MSA.
SOURCES: St. Louis City Health Department; Missouri Department of Health

Exhibit 5. Number of STD Cases, St. Louis City and County: 2013 and 2012

STD Cases	2013 St. Louis County	2012 St. Louis County	2013 St. Louis City	2012 St. Louis City
Chlamydia	5,211	5,379	4,128	4,081
Gonorrhea	1,734	1,923	1,751	1,763
Syphilis	120	110	150	125

SOURCE: Missouri Department of Health